State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Insurance Department
TODD E. KISER
Insurance Commissioner

Bulletin 2013-4(a)

TO: Health Issuers Offering Health Benefit Plans
FROM: Todd E. Kiser, Utah Insurance Commissioner
DATE: December 10, 2013
SUBJECT: Health Benefit Plan Market Transition

The purpose of this Bulletin is to provide health issuers information regarding the filing requirements for non-grandfathered health benefit plans and dental plans in the small employer or individual markets with plan or policy years beginning on or after January 1, 2014; and to address policy extensions.

Small Employer Definition

Utah currently defines a small employer as an employer who, with respect to a calendar year and to a plan year employed an average of at least two employees but not more than 50 eligible employees, on each business day during the preceding calendar year; and employs at least two employees on the first day of the plan year. Issuers should be aware that the Affordable Care Act (ACA) defines a small employer as an employer who employs on average at least one but not more than 100 employees on business days during the preceding calendar year, and who employ at least one employee on the first day of the plan year. As allowed by the ACA, Utah has elected the option to substitute "50 employees" for "100 employees" in the definition of a small employer.

Geographic Rating Areas

Utah has adopted geographic rating areas that vary from the areas proposed by the United States Department of Health and Human Services (HHS). Counties are assigned to the following areas:

Area 1: Cache and Rich
Area 2: Box Elder, Morgan, and Weber
Area 3: Davis, Salt Lake, Summit, Tooele, and Wasatch
Area 4: Utah
Area 5: Iron and Washington
Area 6: Beaver, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne

Age Slope

Utah has adopted an age slope that varies from the slope proposed by HHS. The uniform age rating slope for Utah is:

Age Band	Factor		Age Band	Factor		Age Band	Factor
0-20	0.793		35	1.390		50	2.127
21	1.000		36	1.390		51	2.212
22	1.050		37	1.404		52	2.300
23	1.113		38	1.425		53	2.392
24	1.191		39	1.450		54	2.488
25	1.298		40	1.479		55	2.588
26	1.363		41	1.516		56	2.691
27	1.390		42	1.562		57	2.799
28	1.390		43	1.616		58	2.911
29	1.390		44	1.681		59	3.000
30	1.390		45	1.748		60	3.000
31	1.390		46	1.818		61	3.000
32	1.390		47	1.891		62	3.000
33	1.390		48	1.966		63	3.000
34	1.390		49	2.045		64	3.000

Risk Pools

During the legislature's 2013 General Session in House Bill 160, Health System Reform Amendments, Utah's small employer and individual risk pools were separated. Effective January 1, 2014 Utah law provides for an individual market risk pool, and a small employer risk pool.

Exchange Participation Notification

Each year beginning in 2013, an issuer shall notify the Utah Insurance Department (UID) by no later than April 15th of its intent to offer coverage on an individual exchange, small employer exchange, or both, during the following year. The notification must be provided in writing on company letterhead, signed by an officer of the company, via email at health.uid@utah.gov.

Non-Grandfathered Individual Plans Issued in 2014 - Coverage Effective Periods

An individual policy issued prior to December 31, 2014, shall contain a provision that the plan shall renew on a calendar year basis beginning on January 1, 2015. Deductibles, annual dollar or visit limits, and out-of-pocket limitations shall accrue on a calendar year basis for policies issued on or after January 1, 2014 and beyond, and are not required to be pro-rated for policy periods shorter than 12 months. An issuer shall disclose the date coverage under the plan will renew, and an explanation of the calendar year limitations including deductibles, limits, or out-of-pocket limitations.

Market Transition

Because of the complexity of applying the provisions that the ACA requires to become effective on January 1, 2014, it may be problematic for an issuer to simply amend non-grandfathered plans to incorporate the requirements set out in these provisions. The UID urges all issuers to begin notifying policy and certificate holders of the upcoming changes. In addition to the provisions of Utah Code Annotated (UCA) Sections 31A-8-402.3, 31A-22-721, 31A-30-107 and 31A-30-107.1, there are five options to bring a non-grandfathered plan into compliance.

Option A. An issuer may terminate the non-grandfathered plan by giving 90 day notice as required by Utah law. The issuer must then offer a new policy that fully complies with ACA market reforms. A notice to the policyholders, employees and dependents, shall be provided and include information as to whether replacement policies will be offered inside or outside an exchange, or both. An issuer may, but is not required to, offer to credit a pro-rata share of the deductible and out-of-pocket maximums previously met under the policy that is being terminated.

Option B. An issuer may amend each policy on the first renewal date occurring on or after January 1, 2014 to comply with the ACA market reforms.

Option C. An issuer may amend current non-grandfathered plans to create a plan year that ends on a date prior to December 31, 2013.

- Individual policies. The issuer shall extend the newly renewed policy through December 31, 2014, renewing next on January 1, 2015 and each January 1 thereafter. The newly renewed policy shall apply deductible and policy limits on a calendar year basis. Therefore, the non-grandfathered plan will not be required to comply with the ACA market reforms until January 1, 2015; and the plan year will have been amended to comply with HHS rules. An issuer may renew an individual policy under Option E.

- Small employer policies. The issuer shall offer to renew the small employer plan 12 months from the revised renewal date. Upon the policy renewal on or after January 1, 2014, the issuer shall either amend the plan, as described in Option B; ~~or~~ terminate the plan and offer a compliant plan as described in Option A, or renew the policy as described in Option E.

Option D. An issuer may exit the individual or small employer market effective in compliance with Utah law after submitting and receiving approval of a Plan of Orderly Withdrawal.

Option E. For policies renewing January 1, 2014 through October 1, 2014, an issuer may choose to continue existing non-grandfathered health insurance coverage in the individual or small employer group markets provided the issuer complies with related guidance issued by the Center for Consumer Information and Insurance Oversight related to transition policies, including but not limited to the required notices.

Regardless of the above option chosen by an issuer, such option shall be applied uniformly to non-grandfathered plans on a uniform basis without regard to health status or claim experience.

Please notify the UID of your plans in this regard and provide us with a sample notice letter. Such information and notice letter will be accepted on an informational basis through SERFF.

Qualified Health Plan (QHP) Approval Process

The timeline for submitting QHP rate and form filings to the UID for approval to be used for plan year 2014 is as follows:

- **March 28, 2013 – May 31, 2013**: A health issuer wishing to participate in an exchange shall submit a QHP and an issuer application during this time period.
- **April 15, 2013:** Deadline to notify UID of intent to participate in an exchange.
- **May 15, 2013 – June 30, 2013:** A stand-alone dental issuers wishing to participate in an exchange shall submit an application together with rate and form filings during this time period.
- **July 31, 2013**: Certification recommendations for QHP issuers and QHPs will be forwarded to HHS.

All filings are required to be made within SERFF through SERFF Binders. Individual and small group filings shall be submitted under separate SERFF tracking numbers. Filings shall meet the requirements of Utah Administrative Code Rule R590-220. Forms and rates shall be filed together. Forms filed separately from rates will be automatically rejected. The filing description shall contain information detailing the differences between any cost sharing and metal tier variations being submitted.

Multiple metal and cost sharing levels may be submitted in the same SERFF filing. The schedule pages for each cost-sharing level within a metal plan filing shall have a unique form number and cannot contain variable material. Plans that are being filed for QHP certification shall meet the QHP requirements as detailed below. The UID will utilize the standard templates developed by HHS.

If an issuer chooses to use a previously filed form, the filing description shall include the filed form number and the SERFF tracking number under which the form was submitted. The previously filed form shall also be attached to the Supporting Documentation tab.

Form and Rate Filing Requirements

General Filing Requirements	
Federal Standard 45 CFR 155 and 156 45 CFR 156.20 42 USC §18021 42 USC §18022 42 USC §18031 CMS Guidance Rules ACA §1311 ACA §1002	A QHP issuer shall— (1) Comply with all certification requirements on an ongoing basis; (2) Ensure that each QHP complies with benefit design standards; (3) Be licensed and in good standing to offer health insurance coverage in Utah; (4) Implement and report on a quality improvement strategy or strategies consistent with the standards described within the ACA, disclose and report information on health care quality and outcomes as will later be defined by the Centers for Medicaid and Medicare Services (CMS), and implement appropriate enrollee satisfaction surveys as required by the ACA; (5) Agrees to charge the same premium rate for each QHP of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; (6) Pay any applicable user fees assessed; (7) Comply with the standards related to the risk adjustment program administered by CMS; (8) Notify customers of the effective date of coverage; (9) Participate in initial and annual open enrollment periods, well as special open enrollment periods; (10) Collect enrollment information, transmit such to the Exchange and reconcile enrollment files with the exchange enrollment files monthly; (11) Provide and maintain notice of termination of coverage. A standard policy shall be established and include a grace period for certain enrollees that is applied uniformly. Notice of payment delinquency shall be provided; (12) Segregate funds if abortion is offered as a benefit, other than in the case of an abortion provided under the Hyde Amendment exception; (13) Timely notify the Exchange if it plans to not seek recertification, fulfill coverage obligations through the end of the plan/benefit year, fulfill data reporting obligations from the last plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice; (14) In the event that the QHP becomes decertified, terminate coverage after the notification to enrollees and after enrollees have had an opportunity to enroll in other coverage; and (15) Meet all readability and accessibility standards.
State Standard	UID will utilize a certification approach to reviewing, recommending, and submitting the rate, form and QHP application filing for compliance with federal and state laws and regulations. Certification will be good for a period of one plan year. If an issuer wishes to continue offering a certain QHP following that plan year, the issuer shall apply to have that QHP recertified. Subject to stand alone dental issuers notifying UID of their intent to participate on an exchange, the UID will also require all QHP issuers offering a plan which has pediatric dental imbedded as part of its benefits to also offer an identical plan which does not include pediatric dental as part of its benefits. This requirement will be null and void and all QHP issuers will be required to have an imbedded pediatric dental benefit should no stand-alone dental issuers respond with their intent to participate.

Licensure and Solvency	
Federal Standard 45 CFR 156.200	A QHP issuer shall be licensed and in good standing with the State.
State Standard	A QHP issuer shall be licensed, meet state solvency requirements, have unrestricted authority to write its authorized lines of business, and have no outstanding sanctions in Utah in order to be considered "in good standing."
Network Adequacy	
Federal Standard 45 CFR 156.230 45 CFR 156.235 Public Health Services Act (PHS) §2702c)	A QHP issuer shall ensure that the provider network of each of its QHPs is available to all enrollees and: (1) (a) Includes essential community providers (ECP) in sufficient number and geographic distribution where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service area. This shall be done by demonstrating one of the following during the first year of the Exchange: • That the Issuer achieved at least 20% ECP participation in network in the service area, agreed to offer contracts to at least 1 ECP of each type available by county; • That the Issuer achieved at least 10% ECP participation in the network service area and submits a satisfactory narrative justification as part of its Issuer Application; or • That the Issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its Issuer application. **OR** (b) If an issuer provides a majority of covered services through employed physicians or a single contracted medical group complying with the alternate ECP standard identified within federal regulations, the issuer shall verify one of the following: • That the issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 20% of available ECPs in the service area; • That the issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its Issuer Application; or • That the issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its issuer application. (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder treatment services, to assure that all services will be accessible without unreasonable delay; and (3) Makes its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request noting which providers are not accepting new patients.
State Standard	The UID will require an attestation from the QHP issuer that states it is in compliance with all network adequacy requirements in addition to one of the following: • The QHP issuer provides evidence that it has accreditation from an HHS approved accrediting organization that reviews network adequacy as a part of accreditation; or • The QHP issuer provides sufficient information through a PDF submission related to its policies and procedures to determine that the Issuer's network meets the minimum federal requirements.
Accreditation	
Federal Standard 45 CFR 156.275 45 CFR 155.1045	QHP issuers shall maintain accreditation on the basis of local performance in the following categories by an accrediting entity recognized by HHS: Clinical quality measures, such as the HEDIS; Patient experience ratings on a standardized CAHPS survey; Consumer access; Utilization management; Quality assurance; Provider credentialing; Complaints and appeals; Network adequacy and access; and Patient information programs. QHP issuers without existing commercial or Exchange health plan accreditation from HHS-recognized accrediting entities shall schedule an accreditation review during their first year of certification and receive accreditation on QHP issuer policies and procedures prior to their second year of QHP issuer certification. Prior to the QHP issuer's fourth year of QHP issuer certification and in every subsequent year of certification, a QHP issuer shall be accredited in accordance with 45 CFR 156.275 QHP issuers will be required to authorize the release of their accreditation survey data and any official correspondence related to accreditation status to the UID.

State Standard	The UID will follow the federal requirements related to accreditation and will require the authorized release of all accreditation data. Additionally, UID will require an attestation by QHP issuers not already accredited that those QHP issuers will schedule, to become accredited on policies and procedures in the plan types used, and provide proof of such accreditation on policies and procedures prior to submission of any application for recertification. The QHP issuer shall also indicate that it will receive and provide proof of receipt of full exchange accreditation prior to its third recertification application.
Service Area	
Federal Standard 45 CFR 155.30 & 155.70	Service area is the geographic area in which an individual shall reside or be employed in order to enroll in a QHP. A QHP issuer shall specify what service areas it will be utilizing. The service area shall be established without regard to racial, ethnic, language or health status related factors or other factors that exclude specific high utilization, high cost or medically underserved populations.
State Standard	The state will allow the QHP issuer to choose their service area(s) for year one in as much as service areas may not be smaller than a county.
Rating Area	
Federal Standard 45 CFR §156.255	As it applies to QHPs, the ACA defines a "Rating Area" as a geographic area established by a state that provides boundaries by which issuers can adjust premiums.
State Standard	The UID has adopted a configuration of six rating areas to be utilized in Utah.
Quality Improvement	
Federal Standard 45 CFR 156.20 ACA §1311 ACA §2717	A QHP issuer shall implement and report on a quality improvement strategy or strategies consistent with standards of the ACA to disclose and report information on healthcare quality and outcomes and implement appropriate enrollee satisfaction surveys which include but are not limited to the implementation of: • A payment structure for health care providers that provides incentives for improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage; • Activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional; • Activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; • Wellness and health promotion activities; and • Activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
State Standard	The UID will require an attestation of compliance with quality improvement standards.
General Offering Requirements	
Federal Standard 45 CFR 155 and 156 45 USC §18022 45 C.F.R. § 156.130(a) 45 CFR §147.126 45 CFR §147.120 45 CFR §147.138 CMS Guidance Rules	A QHP issuer shall offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level and a child-only plan at the same level of coverage as any QHP offered through either the individual Exchange or SHOP to individuals who, as of the beginning of the plan year, have not attained the age of 21. Additionally, a catastrophic plan may be filed to be sold on the Exchange in addition to the tiered metal levels. If an Issuer applies to be a QHP issuer in the Individual Exchange, the Issuer shall also apply to offer a policy through the SHOP Exchange. All offerings by a QHP issuer, excluding stand-alone dental issuers, on a single metal tier shall show a meaningful difference between the plans and comply with standards in the best interest of the consumer. Pediatric dental and vision is required to cover dependents to age 19. The QHP shall cover emergency services with no prior authorization, no limitation to participating or in-network providers. Emergency services shall be covered at in-network cost-sharing level. QHP issuers will be required to meet all annual limitation and cost sharing requirements without affecting the actuarial value of the plans within each of the tiers. The QHP issuer shall demonstrate in an Exhibit filed with the Plan that annual out of pocket cost sharing under the Plan does not exceed the limits established by federal regulations. The QHP shall contain no lifetime limits on the dollar value of any Essential Health Benefits (EHB), including the specific benefits and services covered under the EHB-Benchmark Plan.

	For plans issued in the small group market, the deductible under the plan shall not exceed either: • $2,000 in the case of a plan covering a single individual; and • $4,000 in the case of any other plan. Catastrophic plans can be sold to Individuals that have not attained the age of 30 before the beginning of the plan year; or an individual who has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. If offered, Catastrophic Plans are offered only in the individual exchange and **not** in the SHOP. A QHP Issuer shall comply with all federal and state laws related to rating rules, factors and tables used to determine rates. Such rates shall be based upon the analysis of the plan rating assumptions and rate increase justifications.
State Standard	Specific rate and form filing requirements are found below in the filing checklist.
Essential Health Benefits	
Federal Standard 45 CFR 156.115 42 U.S.C. § 18022 45 CFR §147.130 45 CFR §148.170 45 CFR §155.170 45 CFR §156.110 45 CFR §156.125	The QHP issuer shall offer coverage that is substantially equal to the coverage offered by the state's base benchmark plan. This may be done by substituting benefits only if the QHP issuer demonstrates actuarial value of the substituted benefits. A QHP Issuer is not required to offer abortion coverage within their benefit plans. The QHP issuer will determine whether the benefits offered include abortion. If the QHP issuer chooses to offer abortion benefits, public funds may not be used to pay for these services unless the services are covered as part of the Hyde Amendment exceptions. The QHP issuer shall provide notice through its summary of benefits if such benefit is being made available. The QHP shall cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); certain immunizations, screenings provided for in HRSA guidelines for infants, children, adolescents, and women (including compliance with standards related to benefits for and current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention). Additionally, coverage for the medical treatment of mental illness and substance use disorder shall be provided under the same terms and conditions as that coverage provided for other illnesses and diseases.
State Standard	The UID has adopted PEHP's Basic Plus Plan as the benchmark plan to set the essential health benefits for Utah. Attestation from the QHP issuer that states the issuer is in compliance with all Essential Health Benefit (EHB) standards shall be required.
Essential Health Benefit Formulary Review	
Federal Standard 45 CFR 156.120 45 CFR §156.295	The QHP shall cover at least the greater of one drug in every U.S. Pharmacopeial Convention (USP) category and class or the same number of drugs in each category and class as the base benchmark plan. Issuers shall report data such as the following to U.S. DHHS on prescription drug distribution and costs (paid by Pharmacy Benefit Management (PBM) or issuer): Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies; percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type; Aggregate amount and type of rebates, discounts or price concessions that the issuer or its contracted PBM negotiates that are attributable to patient utilization and passed through to the issuer; Total number of prescriptions that were dispensed; Aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.
State Standard	The UID will require an attestation of compliance with EHB formulary standards.
Non-Discrimination Standards in Marketing and Benefit Design	
Federal Standard 45 CFR 156.125 45 CFR 156.200 45 CFR 156.225 45 FR 155.1045 42 U.S.C. § 300gg-3 45 CFR §148.180	A QHP issuer shall: • Be able to pass a review and an outlier analysis or other automated test to identify possible discriminatory benefits; and • Refrain from: o Adjusting premiums based on genetic information; o Discriminating with respect to its QHP on the basis of race, color, national origin, disability, age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation or other health conditions; o Utilizing any preexisting condition exclusions; o Requesting/requiring genetic testing; or o Collecting genetic information from an individual prior to, or in connection with enrollment in a plan or at any time for underwriting purposes.

	A QHP issuer may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.
State Standard	A QHP issuer and QHP shall comply with Utah laws and rules regarding marketing by health insurance issuers. The QHP issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP.
Actuarial Value	
Federal Standard 45 CFR 156..135 45 CFR 156.150	Plans being offered at the various metal tiers within the Exchange shall meet the specified levels of actuarial value (or fall within the allowable variation): Bronze plan: 60% (58 to 62%) Silver plan: 70% (68 to 72%) Gold plan: 80% (78 to 82%) Platinum plan: 90% (88% to 92%) Stand-alone dental plans shall offer plans at either a 70% or 85% actuarial value level.
State Standard	The UID will require an attestation of compliance with actuarial value standards.
Quality Rating	
Federal Standard 45 CFR §156.265 (b)(2) 45 CFR §156.265 (f); 45 CFR §156.400 (d) 45 CFR §156.285 (c) PHSA 2794	HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges with reporting requirements related to all QHP issuers expected to start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Exchanges. The results of such surveys and rating will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements. QHP issuers shall also provide plain language information/data on claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, number of denied claims, rating practices, cost-sharing and payments for out-of-network coverage, and enrollee rights shall be submitted to the exchange, HHS, and the state insurance commissioner.
State Standard	The state will adopt the Quality Rating Standards as provided in federal guidance.
Rate Filing	
Federal Standard	Premiums may be varied by the geographic rating area, but premium rates shall be the same inside and outside the exchange. • Rating will be allowed on a per member basis. • Premium rates may vary by individual/family, rating area, age (3:1), and tobacco use (1.5:1) All rates filed for individual QHPs will be set for an entire benefit/plan year.
State Standard	The UID will continue to effectuate its rate review program and will review all rate filings and rate increases for prior approval. Rate filing information shall be submitted to the UID with any rate increase justification prior to the implementation of an increase.
Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR §155.1030 45 CFR §156.420	The QHP issuer shall offer three silver plan variations for each silver QHP, one zero cost sharing plan variation and one limited cost sharing plan variation for each metal level QHP. Silver plan variations shall have a reduced annual limitation on cost sharing, cost sharing requirements and AVs that meet the required levels within a de minimis range. Benefits, networks, non-EHB cost sharing, and premiums cannot change. All cost sharing shall be eliminated for the zero cost sharing plan variation. Cost sharing for certain services shall be eliminated for the limited cost sharing plan variation.
State Standard	The UID will require an attestation of compliance with plan variation standards.

Filing Checklist

✓	**QHP Issuer Application Receipt**
	Exchange application data is complete
	Explanation:
	Page Number:
	Final QHP Issuer Application Submission Attestations, including: Service Area Attestation Rating Areas Attestation Network Adequacy Actuarial Value Marketing Regulations and Transparency Market Reform Rules Licensure and solvency Compliance with Essential Health Benefits Accreditation
	Explanation:
	Page Number:
✓	**Accreditation and Quality Standards**
	Applicant has *exchange* accreditation through NCQA and/or URAC, or: **Year 1-** Applicant has applied for *exchange* accreditation through NCQA and/or URAC **Year 2-** Issuer procedures and policies are accredited
	Explanation:
	Page Number:
	Exchange accreditation is based on the following standards: Clinical quality measures, such as the HEDIS Patient experience ratings on a standardized CAHPS survey Consumer access Utilization management Quality assurance Provider credentialing Complaints and appeals Network adequacy and access Patient information programs
	Explanation:
	Page Number:
	Release of accreditation data has been authorized
	Explanation:
	Page Number:
✓	**Cost-Sharing Reductions**
	Three silver plan variations for each silver QHP
	Explanation:
	Page Number:
	Eliminate cost sharing for an Indian (Section 4(d) of the Indian Self-Determination and Education Assistance Act) with a household income of 300 percent of the FPL who is enrolled in a QHP at *any level of coverage*
	Explanation:
	Page Number:
	Cost-sharing incurred under plan do not exceed the dollar amount limits established by federal and state laws and regulations.
	Explanation:
	Page Number:

✓	Benefit Design
	Actuarial Value
	At least one QHP at each of the following Actuarial Values: Gold: 80% (78 to 82%) Silver: 70% (68 to 72%) Child-Only (at same level of coverage)
	Explanation:
	Page Number:
	Actuarial Memorandum and Certification Received Verification that plan is substantially equal to benchmark plan Compliance with premium rating factors including: Self-only or family enrollment, Utah geographic rating areas (6 areas) Utah age slope (3:1 for adults) Tobacco use (1.5:1) Justification information for rate increase, if applicable
	Explanation:
	Page Number:
	Emergency services Emergency Care Services
	Explanation:
	Page Number:
	Hospitalization
	Explanation:
	Page Number:
	Maternity and newborn care
	Explanation:
	Page Number:
	Mental health and substance use disorders, including behavioral health treatment
	Explanation:
	Page Number:
	Prescription drugs Prescription Drugs: Plan covers at least the greater of: (1) one drug in every category and class; or (2) the same number of drugs in each category and class as the EHB-benchmark plan
	Explanation:
	Page Number:
	Rehabilitative and habilitative services and devices Physical, Occupational, and Speech Therapies Durable Medical Equipment Prosthetic and Orthotic Devices Medical supplies
	Explanation:
	Page Number:
	Laboratory services Testing and Evaluation
	Explanation:
	Page Number:
	Preventive and wellness services and chronic disease management Preventive Health Services Routine immunizations US Preventive Services Task Force A or B rated benefits
	Explanation:
	Page Number:
	Pediatric Dental (if applicable)
	Explanation:
	Page Number:

	Pediatric Vision
	Explanation:
	Page Number:
	Additional State Benefits Diabetic Supplies/Education Dietary products including formula and low protein modified food
	Explanation:
	Page Number:
	Mandated Persons Covered Adopted Children Handicapped Dependents
	Explanation:
	Page Number:
✓	**Discriminatory benefit design**
	Plan does not employ benefit designs that have the effect of discouraging the enrollment of individuals with significant health care needs
	Explanation:
	Page Number:
	Benefits not designed in a way that discriminates against individuals because of age, disability, or life expectancy
	Explanation:
	Page Number:
✓	**Meaningful difference in benefit design**
	Plan does not employ benefit designs similar to other plans
	Explanation:
	Page Number:
✓	**Pre-existing conditions**
	Plan shall contain no preexisting condition exclusions
	Explanation:
	Page Number:
✓	**Market Reform Rules**
	QHP compliance with market reform rules in accordance with state and federal requirements
	Explanation:
	Page Number:
	Attestation of QHP compliance with market reform rules in accordance with state and federal requirements.
	Explanation:
	Page Number:
	Cost-sharing incurred under plan does not exceed the dollar amount limits established by federal and state laws and regulations (currently for individuals with household incomes between 100 and 250 percent of the FPL.)
	Explanation:
	Page Number:
✓	**Network Adequacy**
	Essential community providers
	Explanation:
	Page Number:
	Accredited policies and procedures that includes network adequacy
	Explanation:
	Page Number:
	Evaluation of issuer's network detailing issuer's ability to meet network adequacy standards including company policy for ensuring an adequate network
	Explanation:
	Page Number:
	Provider directory is available for online publication
	Explanation:
	Page Number:
	Provider directory available to individuals in English and Spanish
	Explanation:
	Page Number:

✓	**Rating Areas**
	Attestation of compliance with state rating areas (6 rating areas)
	Explanation:
	Page Number:
✓	**Service Areas**
	Issuer service areas specified
	Explanation:
	Page Number:
	Service area covers a minimum geographical area that is at least an entire county, or group of counties
	Explanation:
	Page Number:
	Service area is established without regard to racial, ethnic, language, health status related factors, or other factors
	Explanation:
	Page Number:

If you have any questions or comments, please call the Health and Life Division at 801-538-3066 or email us at health.uid@utah.gov.

DATED this 10th day of December 2013,

Todd E. Kiser
Insurance Commissioner